CABINET FOR HEALTH AND FAMILY SERVICES ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

July 24, 2014 10:00 A.M. Room 125 Capitol Annex Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin CHAIR

Donald Neel
Sharon Branham
Susanne Watkins
Peggy Roark
Oyo Fummilayo
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING

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AGENDA

| 1. | Call to Order 3 |
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| 2. | Approval of Minutes from March & May, 2014 3 |
| 3. | Old Business * Uniformity of preauthorization forms/ procedures |
| 4. | Updates from Commissioner Kissner 34 - 60 |
| 5. | Reports and Recommendations from TACs * Behavioral Health |
| 6. | Approval of Recommendations from TACs and request for response from DMS |
| 7. | New Business 77 - 79 |
| 8. | Other 79 |
| 9. | Adjourn 79 |

CHAIR PARTIN: We will go ahead and get started. We do not have a quorum this morning but we'll go ahead and start conducting the meeting in any case.

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The first item on the agenda was approval of the minutes from the last meeting and from the meeting before. We will not be able to approve those minutes today.

Under Old Business, uniformity of preauthorization forms and procedures. What this item is is that with all of the Medicaid MCO's and with Medicaid itself, there are various preauthorization forms that are required and procedures that have to be followed in order to get authorization for certain medications and procedures, and each of the MCO's and Medicaid has a different form and a different procedure for authorizing medications or procedures.

And, so, we would like to ask that there be some mechanism that perhaps we can work with the MCO's and Medicaid in having some kind of commonality with these forms. Now, we're not talking about saying that the medications or the procedures that are approved by each of those entities has to be the same. What we're really asking is that the process of getting authorization be similar.

| 1 | Do we have representatives from | |
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| 2 | all of the MCO's here today? Yes? | |
| 3 | COMMISSIONER KISSNER: We should. | |
| 4 | CHAIR PARTIN: And I know we have | ž |
| 5 | Medicaid people here. | |
| 6 | COMMISSIONER KISSNER: You could | |
| 7 | call roll. | |
| 8 | CHAIR PARTIN: Okay. Barbara, | |
| 9 | would you do that for me? | |
| 10 | COMMISSIONER KISSNER: Passport. | |
| 11 | PASSPORT REPRESENTATIVE: Here. | |
| 12 | COMMISSIONER KISSNER: Coventry. | |
| 13 | COVENTRY REPRESENTATIVE: Here. | |
| 14 | COMMISSIONER KISSNER: WellCare. | |
| 15 | WELLCARE REPRESENTATIVE: Here. | |
| 16 | COMMISSIONER KISSNER: Anthem. | |
| 17 | ANTHEM REPRESENTATIVE: Here. | |
| 18 | COMMISSIONER REPRESENTATIVE: | |
| 19 | Humana/CareSource. | |
| 20 | HUMANA/CARESOURCE REPRESENTATIVE: | |
| 21 | Here. | |
| 22 | CHAIR PARTIN: Thank you, | |
| 23 | Commissioner. So, since we have representatives from | |
| 24 | all of the MCO's here, if you would come forward and | |
| 25 | express what your feeling is on maybe developing some | |

kind of commonality with the forms and with the procedures. Is that something that we can all get together and discuss? Yes? Could you all come forward.

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MS. BRANHAM: Beth, you might want to be explicit when you're saying a form that has commonality to request for specific services or maybe expand on that just a little.

MS. PARTIN: There are seats down at the end of the table here. So, just to elaborate a little bit, this has to do with the forms that are required that practices or providers or agencies need to use in order to get approval for services or procedures or medications.

Each of the MCO's and Medicaid has different forms and different procedures for asking for authorization. So, again, we're not asking that everybody be the same in what you authorize. What we're asking is that the forms and the procedures that we have to go through in order to get things approved be similar because it really is a crazy nightmare in practice trying to get these things done, especially when every single one of them is different.

COMMISSIONER KISSNER: So, if I could put it in a little bit different perspective, there is a nationally-recognized, uniform claim form.

So, let's take a vote. Are you open to a universal form for prior authorizations? It's kind of a yes or no.

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MR. ORRIS: I'm Ben Orris, COO for WellCare, and we would be happy to work collaboratively to discuss what this committee is proposing.

One thing I would caution is each entity has their own standard forms nationally is what you're going to run into. So, WellCare who operates in thirteen states and CareSource who operates in multiple states, everybody is going to have an issue that we standardize our processes nationally.

So, what we're going to run into, and I'm not saying that we can't, but I'm saying we'll be happy to discuss and see what kind of compromise, how we can make it easier; but I can tell you now, it's probably going to be a challenge that we run into is getting approval to make sure that we're streamline and efficient on a national basis as well but certainly happy to entertain.

I don't know if there's a Pharmacy Technical Advisory Committee. Would that be who this runs through?

CHAIR PARTIN: No. It wouldn't necessarily be through pharmacy because there's all different providers. There's home health, there's the

health care providers.

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 $$\operatorname{MR.}$ ORRIS: I'm sorry. I thought we were dealing specifically with pharmacy. It's all auth processes.

CHAIR PARTIN: Yes. It can be medications but it can also be services and it can also be procedures like x-rays or MRI's or those kinds of things. It can be referrals. Some of you require authorization for referrals.

So, there's a big gamut, and some of the MCO's require that we go online to do forms and some don't and some want them faxed and some want them called; and the forms, besides the procedure of how to do it, the forms all are different.

MR. ORRIS: Right. Well, and I think we try to cater to the provider mechanisms that they have in place, too. We try to make it as convenient as possible, whether it's most convenient for this provider to do it online, while it's more convenient for this provider to do it via fax, while it's more convenient for this provider to phone it in. So, we want to always keep all availability open to the provider based on their setup.

DR. NEEL: I may be off base, but wouldn't this be a place where the Medical Directors who

meet with Dr. Langefeld could discuss this and see if there's not some commonality? Could that not be in that forum that exists every month?

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ANTHEM REPRESENTATIVE: That could be a possibility; however, the physicians aren't often engaged on the front-line authorization process. So, it's a little bit more operational.

DR. NEEL: All right. Then, is there an operations committee that meets with somebody that could do it?

COMMISSIONER KISSNER: We meet with the MCO's on operation stuff at least monthly. We do it individually to deal with their own operational issues.

MS. BRANHAM: Why couldn't we take the Medicaid forms that have been used in Kentucky for a number of years and look at those and let it be the jumping-off point to see if the MCO's that are doing business here could utilize those forms?

ANTHEM REPRESENTATIVE: Anthem would be willing to do that. One thing we're going to have to look at is all the different services which are rendered to the members.

For example, we have recently worked with the Hospice Association. Our prior

authorization form didn't meet their needs for all the different services and all the items that they do provide the members. So, we actually worked with them to create their own form.

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MS. BRANHAM: But, there again, the State did. The ones that were utilized for the State prior to you all coming in did meet all the needs of what the providers are requesting for services, whether it's transition of levels of care or what-have-you.

So, this stuff is in place and we just threw the baby out with the bath water, so to speak. The forms that Kentucky had were forms that all providers used to request their services. So, those are there and are available as a jumping-off point to see if you all could utilize those to get the information that you request for services that we're requesting to provide.

ANTHEM REPRESENTATIVE: And our point would be in line with WellCare's and moving forward with those discussions.

HUMANA REPRESENTATIVE: For Humana/CareSource, we're more than willing to look at

those forms as well as meet as a group and review the forms that are out there and see if we can come up with something that would work for everyone.

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I think the differences, of course, are going to be the differences in our prior auth list. Some of us preauth from the very beginning. Some preauth when it comes to, say, twenty visits. So, the information may be different.

think it's the prior auth list. That's not on the table, clearly not on the table. It's the form that you use to request any possible thing that needs to be requested. And whether you telephone it or you do it online or you fill out a paper form, you're still getting the same information from the provider that says here's all the stuff I need. So, that's one.

And, then, the second thing is the process which I think was well-represented by WellCare in that you want all of the--you don't want to say everybody has to use paper because that would be crazy, and you don't want to say everybody has to use phone because that would be crazy, or everybody has to go online. We have one pathway. So, we want multiple pathways.

I don't think we're trying to

1 determine the process. We're not shutting down any of 2 the availability that's there today because more is better in that regard, but it's the form. Can it be 3 unified, right? 4 5 MS. BRANHAM: Well, we have a unified form. 6 7 COMMISSIONER KISSNER: Do not make the assumption that fee-for-service Medicaid was the 8 9 gold standard. 10 MS. BRANHAM: I'm not, but it 11 certainly would be a jumping-off point. 12 COMMISSIONER KISSNER: Of a cliff maybe. 13 14 MS. BRANHAM: Oh, I disagree. 15 disagree. 16 COMMISSIONER KISSNER: These guys are doing much more--you know, they're asking questions 17 18 we never even asked before. So, how do you put that in a form? Yes, it's a starting point of saying here's a 19 2.0 form that has been operating in the State of Kentucky 21 for a lot of years; but, then, you get to what's not 22 there, what questions, the process for subsequent requests, but, yes, it's a starting point. 23 24 I'm just kind of teasing but it's

a starting point. You could start anywhere with any

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1 starting point and say how are the others different, but 2 so far we've got three people willing to have an 3 operational meeting. We've got three yeses for a 4 5 meeting to discuss it. PASSPORT REPRESENTATIVE: 6 7 Passport absolutely would be happy to do that as well. COMMISSIONER KISSNER: 8 9 yes. We've got one more. PASSPORT REPRESENTATIVE: The only 10 11 thing I would add is that it's not just one form. 12 There's a different form for every service. CHAIR PARTIN: And that kind of 13 14 gets to the meat of the matter is that there are 15 different forms for all these different services. And 16 then you magnify that by six and it's crazy. 17 And, so, I don't think we're 18 saying that there's any particular form that we prefer. We would just like something similar. 19 2.0 MS. BRANHAM: If we request 21 services for, for example, skilled nursing from 22 Passport, WellCare, whatever, that's a specific form, or 23 if we ask for aide services or whatever it may be,

served our needs fairly well. That's all we're saying.

that's a specific form that we've utilized that has

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Whether you request this or whether you request that, those forms are already there and in place. They can modified for whatever the provider is asking for, whether it's an x-ray or an MRI. That's all in place, been in place for years.

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MR. ORRIS: And I think in theory, it's a great idea and it would certainly streamline and make office life easier for all the providers and the operations. It's going to be a challenge, not one that we can't overtake.

A large of our percentage of our auths come in through online. So, you're talking about rebuilding online forms and those feed into certain fields within production systems. So, to try to get that sort of portal changed and similar for all plans, which every plan has a different referral portal, it's easy to change a piece of paper. It's a little bit more challenging to change an intake portal.

I'm not saying it can't be done, just saying it's not something that will resolve in a few months. It could be long, but if we keep attention and focus on it, it probably can be done.

CHAIR PARTIN: Okay. Then, can we ask that you all get together and have a meeting and discuss this and see if there is some way to come up

| with some kind of commonality? |
|--|
| COMMISSIONER KISSNER: We need to |
| hear from Coventry/Aetna. |
| COVENTRYCARE REPRESENTATIVE: |
| We'll abstain. |
| CHAIR PARTIN: You're not going to |
| participate in the meeting? |
| COVENTRYCARE REPRESENTATIVE: Yes, |
| we are participating. I'm just not authorized to make |
| that commitment. |
| CHAIR PARTIN: Just to meet? |
| COVENTRYCARE REPRESENTATIVE: I'm |
| not authorized to make that commitment. |
| DR. NEEL: Okay. That's fine. |
| COMMISSIONER KISSNER: So, we'll |
| take the lead. We'll coordinate the meeting. We'll |
| request copies from the MCO's. So, Patricia and Lee, if |
| you're in the room, this is what we want. We want |
| copies of all of the current forms. |
| We'll get them because if you've |
| designed, like we heard, a specific hospice form for the |
| needs of the hospice providers that was unique to them, |
| who knows if that's been done across the board. We |
| could have twenty different forms that meets the needs |
| |

of all those providers but it's twenty for one plan.

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So, we'll get those.

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We'll assume that the paper form is essentially the electronic equivalent of whatever is online because you've got to ask the same information. We'll get that first. We'll do a quick overview and then we'll set up the meeting and have a discussion.

CHAIR PARTIN: Thank you. The next item is the selection of health indicators. And, Dr. Langefeld, you were going to come back to us with a proposal.

DR. LANGEFELD: I was. Good morning. Thank you for the opportunity to speak with you again.

This is really a continuation of our discussion the last two meetings around the request from the Commissioner to identify and make a recommendation for a common Performance Improvement Project that will be the focus of all of the health plans in the next cycle.

And, so, last month we went through a number of opportunities. In Kentucky, we have many opportunities as we've discussed. And, so, today what I'd like to do is review. Your guidance to me was to have me make the recommendation about what I thought we should focus on. So, I'm here today to do that.

So, if you will go in your binder in Section 12. The easiest way is to go completely to the back and work forward and you will see this presentation that's dated for today, July 24th. It's titled Quality Performance Improvement Project Recommendation. It should be the one that has today's date on it. I think the one from the last meeting is also in there.

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So, let's move through this. Much of this we reviewed as part of the discussion last month, but I really wanted to, as context for the recommendation, go through some of this to reiterate and to highlight some of the importance of why this recommendation is important.

So, let's go through this. The first or the second page essentially is what we should all keep in mind as we focus on our primary objective, and for us, that is what we call the Triple Lane - for better healthcare for our population, improved health and care for our individuals, and what I like to call stewardship of our fiscal needs, fiscal responsibilities.

The next page, page 3, really just highlights, I think, what you already know and that is our age distribution of our Medicaid recipients in

Kentucky. Now, as you also know, this demographic, this distribution is going to change significantly this year with expansion and coverage for particularly adult males; but what will not change is the preponderance of children and youth in this population.

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So, let's review that quickly. We talked about it last time - 577,604 Medicaid and KCHIP children. There's no county in our 120 counties in our state that do not have Medicaid-covered or CHIP-covered children. A hundred and five thousand children were under the care or service of our KCHIP Program. And the next page, 6, over 11,000 also were foster children. That's a cumulative total in 2013, and you see the map distribution of our foster children there.

So, with that context, the next page, which is page 7, you will see again where we talked about 42% of all children in our state are covered under Medicaid and/or KCHIP. And from a percentage standpoint, you can see the distribution. There are very few counties in our state, in fact, four to be precise, that have less than 30% of the children that are not Medicaid and/or CHIP eligible and covered. So, for Kentucky, this is a significant population and an area we should focus on.

Page 8 again reviews at a national

level where we are, and red is not indicative of conservative or liberal leanings. It is bad. It means that we are one of the states at 11.1% or more of children and youth that have had a diagnosis. So, on a relative scale, we're in that highest category.

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And the next page, page 9, actually gives a little bit more granularity to that, and we talked about this last time as well. From 2003 to 2011, we had an increase from 10% to almost 19% of children who had a diagnosis of ADHD compared to the national average of 7.8% to 11%, so, almost double the national average.

And from a standpoint of taking medications, we changed from 2007 where we were at 7.1% to 2011 where we're at 10% of those receiving prescriptions. That's the second highest in the country for receiving prescriptions for medications for this treatment.

The next page, page 10, gets at the other when we're talking about what I call psychotropic medications and certainly psychotropic medications in children. And there are many medications in this category, but the two categories that I'm highlighting here are, number one, those drugs that are used to treat ADHD, ADD, ADHD which are primarily

stimulants, amphetamine, methamphetamine,, and, then, secondly, what we call the atypical antipsychotics.

This page 10 highlights a brief that was put out about a year ago actually by CMS and HHS around a concern, an issue of concern of atypical antipsychotics in pediatric use.

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And as they highlight here, and these are just excerpts, and I put the URL if you'd like to visit that website and look at it in more detail, but they raise the issue of a concern of prescriptions used outside of the FDA-approved guidelines for use of these medications.

They go on to highlight the fact that very young children with behavioral problems, the treatment doubled between 2001 and 2007, and that the FDA approval for this class of medication is for no children under the age of five.

Now, we know that there's a lot of off-label use. So, this is not a dialogue about label versus off-label.

Here's the thing that's important particularly about this class of drugs. This is a very potent, what we call psycho-active chemicals. They have impacts in our brains and our chemical interactions in our brains. We do not know the extent of the impact

that these drugs have on a developing young brain and what the long-term implications of that is. That's true of many different drugs, but these drugs in particular have a significant side-effect profile overall. They have a significant what we call cardio-metabolic impact, weight gain, diabetes, cardiovascular issues, so, side effects in addition to potentially alterations of a developing brain that we do not know yet.

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So, it is important that they're prescribed under the direction of someone who can monitor that appropriately, who can diagnose appropriately, who can treat effectively with the best outcomes.

And, so, with that in mind, the next page, let's look at the data from Kentucky. In Kentucky, of the total population that we talked about before, 82,564 children received psychotropic medication prescriptions in 2013. So, that's 14% of our total population. In our foster children, 4,600 which was 42% of our foster children received prescriptions in this class of medications.

Now, if we compare that to what I'll call a national average - this is nine states, but it was 5.4 million, so, it was a good comparison population. So, in an issue that already has been

identified at a national level as an issue of concern at 7%, we are at 14%. So, we're double what already is considered a concern. For foster children, we're at 42% compared to 26% nationally.

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That doesn't even get into the question of what's so significantly different about foster children that they receive that proportionally higher prescribing of psycho-active drugs? That's a question we don't know. We don't have the answer.

The next page really just gives you - and I won't spend a lot of time - I just wanted to highlight - the distribution of ages. And you see, of course, the major ages are those early years, but you also see that there are significant numbers in this age of zero to five years of age in both of these categories and overall.

The next page on 13 really gets at has it changed, and, in fact, and, unfortunately, we have not seen a reduction in our trend and utilization of these prescriptions over the last three years either.

So, the summary of concerns are listed on page 14. Kentucky has one of the highest rates in the U.S. of psychotropic medications prescribed to children. The psychotropic medications are being prescribed to very young children at levels above those

approved in adults and often in combination with other medications.

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The other thing our data shows is that we have multiple children with multiple prescriptions in the same class, meaning getting two drugs or more in the same class of drugs - two or more antipsychotics, two or more stimulants at the same time, many times by different providers.

Our rate of use for foster children is nearly six times that of our TANF population and Medicaid.

So, our question is how should we respond to this? So, I wanted to highlight what we've done already.

We've completed a preliminary analysis of our Medicaid claims data. We know a lot about this already from our data. We've also had preliminary discussions with all of our MCO's. In our Medicaid Director meeting and other forums, we've had multiple preliminary discussions about this topic.

We've also had some preliminary discussions with the University of Lousiville,

Department of Pediatrics. One of the reasons for that around this topic is unique actually to that faculty is that the Child and Adolescent Psychiatry is actually

part of the Pediatrics Department there which is atypical, meaning in most institutions, that is not the case. Child and Adolescent Psychiatry is actually in psychiatry.

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So, anyway, we have engaged them. They've put together a multidisciplinary research team. They have a fairly creative title called Child and Adolescent Health Research Design and Support Team. I guess that stands for CAHRDS, but they've been engaged.

And here's the question that we've asked them today. We want them to validate and refine our initial analysis; secondly, to research clinical, evidence-based best practices nationally because this is an evolving field obviously in prescribing and treatment; make recommendations regarding potential programmatic actions; be actively involved in continued research, education and interactions with our treating physicians and providers; and make recommendations on appropriate and effective quality outcome metrics that can be utilized.

So, this comes to our last page which is the recommendation that I have for you. So, it is requested that the Medicaid Advisory Council respond to this issue of concern involving our Kentucky children by supporting the recommendation for a common

Performance Improvement Project focused on effectiveness of treatment that includes the use of psychotropic medications in children be adopted and implemented in accordance with the contractual requirements of all Kentucky Medicaid MCO's, and I have put the language in the contract below.

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So, that's my recommendation to you, and I'll be glad to take any questions you might have.

CHAIR PARTIN: I have a question. What would be the parameters or what would you be asking the providers to report in this PIP for measuring a quality measure? What would the measure be?

DR. LANGEFELD: Well, when I say measures, there will be several ways we look at this. From more of a data analytic standpoint, we'd be looking at what's actually occurring as far as how many medications and what the medications are and what they're being prescribed for, etcetera.

From a monitoring standpoint, that's what we're yet to define. Unfortunately, there are very few nationally recognized. For example, HEDIS, which is typically what we're using for a lot of our quality metrics, has somewhat of a paucity of good, well-developed metrics around this topic itself.

There are some that sort of get at it indirectly, but one of the things we'll be working collectively together is to say what are the metrics we're going to use to monitor the impact, positively or negatively, and make sure we're improving the outcomes

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that we desire in this.

CHAIR PARTIN: So, initially, basically you would just be asking are you prescribing this medicine and what is your diagnosis?

DR. LANGEFELD: Those are things that we'll be looking at in the study itself, right.

The Performance Improvement Project will identify an area of focus.

With that area of focus, then, the whole programmatic activity around what are the things we're looking for which is what you're getting at, what are the metrics we're tracking, what are the benchmarks we're comparing it to, what are the things that reflect quality of care. Part of the reason we've engaged the pediatric faculty is to help us make sure we're doing this in the most effective way.

CHAIR PARTIN: So, I guess what I'm getting at is more of a basic thing. What will you be asking the providers to report for this measure?

DR. LANGEFELD: There may be some

requests of providers for reporting, but a lot of this can be accumulated initially out of claims data. Did the prescription occur? What was the diagnosis of the interaction? What providers did they see? What was the speciality designation? All of that information, just like a lot of the quality metrics, we can obtain that information from our claims data itself.

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If there are identified other things that we think collectively may give us more granularity around this whole area, those are things that we would have a discussion with our providers about.

CHAIR PARTIN: Thank you.

DR. LANGEFELD: What the request is, I guess, from the committee's standpoint is we don't have all of the final details of this which we'll outline but just agreement that this is an area we want to focus on.

DR. NEEL: I'm glad you chose this really. I was afraid you were going to come back with obesity and trying to get our arms around that figuratively is even worse, but I don't think we're getting our arms completely around this.

I can tell you as a pediatrician, it's a huge issue but we've got to talk about some other

things. There are a lot who would argue that we're not diagnosing enough ADHD and that really Kentucky is on the forefront maybe than some of the other states and there is more ADHD. So, that could be argued, and, so, you've got the right people looking at that.

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But you've got to add some other people that I don't see mentioned here. One is the school system because we're getting tons of recommendations for kids being treated - don't bring Johnny back tomorrow until he gets on medicine for his ADHD. We're not willing to just run him around the playground for thirty minutes and whether that would work.

In the old days, we really had another way of treating ADHD other than just medications and that was one-on-one treatment. If you could, can we afford that kind of thing? So, non-medication treatment of ADHD is obviously something that needs to be talked about.

Another is the Drug Enforcement people because the diversion of these drugs is huge in spite of what Shire says that there's no way to divert Vyvanse and that sort of thing. It's simply not true.

And, then, the third is to talk to the Disability people because I've even had them to my

office because a pretty sharp mother with four kids can get all four kids determined as being disabled if she gets them on ADHD meds. That's just insane to me, but that's law. That's the problem that we couldn't change that.

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So, there are some other things we need to get around, and maybe you know all those things obviously, Doctor.

DR. LANGEFELD: Thank you very much. Absolutely. This is not something we look at isolated. We have to look at this in a very holistic way, all the things that drive it. You identified some of them very effectively. We know that teachers say, look, this child is out of control. They need to be on medication, right? It happens every day. The issue around disability and sort of the incentives around that, whether they're appropriate or not. The diversion is a huge issue. We know that has driven a lot of the escalation, particularly around the stimulants.

And, so, absolutely. That's part of what this should include is a very holistic look at this to understand it, number one. That's where the research comes in. Number two, then, programmatically, how do we address all of these touch points around this issue?

DR. NEEL: Okay. That's fine.

Just be sure that you include some of the people in the trenches that are outside the university situation.

DR. LANGEFELD: Absolutely.

DR. NEEL: We can't vote to accept the recommendation but I certainly think we should.

CHAIR PARTIN: We can't vote to accept it, but I guess since we had agreed at a previous meeting to accept your recommendation, are we all in agreement here, those of us that are here, that we like this?

MS. BRANHAM: I think we did at a previous meeting. That's what we asked for, so, I think that should suffice.

DR. NEEL: So, are you ready to get started on that immediately because I know I sit on one of the quality committees of one of the MCO's and it comes up every single time? One of the MCO's I know is forming their own committee to do it. And, so, is that going to get coordinated within and with out?

DR. LANGEFELD: Absolutely, and that's part of the reason we're trying to move this forward because they're on a cycle and they're already in the process of many of these decision points. And, so, we need to make sure we're all in sync with that.

CHAIR PARTIN: Thank you very

much.

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The next item has to do with something that we've talked about before with WellCare, requiring preauthorizations for mental health visits fourteen days prior to the patient's visit.

This is problematic for a number of reasons. Patients are not required to have a referral and they rarely bring a card to an appointment date. And, so, it's difficult to get prior authorization fourteen days before a visit when you don't know that the patient is a WellCare patient and they need preauthorization.

Also, this only applies to the psych mental health visits. It doesn't apply to other healthcare providers. And, so, this places patients at risk who need mental health services because if they're not preauthorized, then, the provider can't get paid for that visit or maybe they'll reschedule the patient for another time when that patient may need services on that day.

It's a barrier for the mental health providers getting paid for routine services, and also providers weren't notified in writing of this change. There is information on a document that went

into effect in November of 2013 but this wasn't presented to the providers or publicized. The person who gave me this information said you had to really dig to find it.

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So, we would like WellCare to address this problem.

MS. GORDON: Absolutely. Lori
Gordon from WellCare, and I think we've addressed this a
couple of times before. There is no requirement for
fourteen days prior to an authorization. It's never
been a requirement, never will be a requirement to my
knowledge.

The information that I think is being referenced where there's the only thing I can think of that's a fourteen-day is that clinical information presented for prior authorization should not be more than fourteen days old, meaning that if you're requesting a review, a concurrent review today, we don't want you to give us clinical information from twenty-two days ago to support your request. We want the information for the clinical authorization to be current, so, happening currently.

We respond to any authorization request for mental health treatment on an outpatient basis, which I think is what this is referencing, within

1 two days. And, so, we need to have the request as 2 quickly as possible, but there's no fourteen-day 3 preauthorization request. We clarified that on a letter after the last MAC meeting. This keeps coming but 4 5 there's never been a requirement. 6 CHAIR PARTIN: Who did you send 7 the letter to? MS. GORDON: We posted it on the 8 9 website and changed the form. It's just clarifying to say that the clinical can't be more than fourteen days 10 11 old, not that you're required to--I mean, I don't think 12 anybody has a crystal ball. We're not asking people to know in advance of somebody needing clinical treatment. 13 14 CHAIR PARTIN: Okay. So, if a 15 patient is discharged from the hospital and they're 16 scheduled for an appointment seven days with a 17 provider----18 MS. GORDON: That would make me 19 very happy, but, yes, go ahead. 2.0 CHAIR PARTIN: And then they show 21 up at the provider's office seven days later, that 22 provider doesn't have to do any prior authorization in order to see the patient that day? 23 24 MS. GORDON: Correct.

CHAIR PARTIN: That information

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hasn't filtered out to providers. And, so, I think it would be helpful to have an actual letter or an email sent to providers rather than just posting something on the website.

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MS. GORDON: Okay. We can do that again. We did send it to Impact Plus providers and CMHC providers and we covered it in at least three conference calls, but we'll send a letter to our whole provider list, that's fine, or an email.

CHAIR PARTIN: I think that would be helpful because those in private practice aren't getting this information. Thank you very much.

The next item was a request for Commissioner Kissner to report on his May 22nd meeting with the Governor. He was going to meet that day, but I will leave that until the Commissioner gives his updates to us.

And, then, the last item under Old Business came up at the very end of the last meeting where the Primary Care TAC reported about a delay in approval for rural health clinic Medicaid rates by the State. And the Commissioner noted that the delays came because there were in some cases challenges to the rates being set and that when there were challenges, that it took longer because attorneys had to get involved and so

on and so forth and it could take a long time.

2.0

I guess my question is, what if there are no challenges? What if it's just a straightforward rate approval and there's no objections from anybody and the practice is just waiting for the rate approval?

MR. BOLT: David Bolt, Kentucky
Primary Care Association. We did have our TAC meeting
Monday of this week, and I'm very happy to report there
was significant progress on that and other issues.

And, in fact, DMS staff has agreed to sit down with a number of FQHC's and RHC's that are experiencing some financial difficulties as a result of wrap payment issues and the rate-setting.

So, I think on a happy scale, we're about 50%. And HEDIS measures, we'd like to get to 75%, but it's very good progress and appreciate the Commissioner and his staff on that.

CHAIR PARTIN: Thank you. The next item, then, is updates from Commissioner Kissner.

COMMISSIONER KISSNER: So, I'm not going to go through the whole binder for you. It's the same sequence that we have had for many, many meetings now, and we're getting it online as quickly as we can after the meeting.

I do have a handout for you. One is we're doing a series of Medicaid forums, and, so, we want you guys to get out—we have already put this online. We've already sent a communication. This letter went out earlier, July 8th, to all providers in the state with the exclusion of long-term care because they have really no involvement with managed care at this point.

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So, we sent this out to all providers, all provider types, and there's a series of MCO meetings. And, then, on the back, you can see a sample of what the days are going to look like. It's a two-day conference. There's a \$25 registration fee. If you go online, you can click on those online links there and do the registrations.

There's a General Session.

There's a Medicaid Update. There's a DOI Update and then Behavioral health, the Governor's Goals on Improving Health, and then a Q&A by the Cabinet with the people that are in attendance, and then we actually provide lunch. That's part of the \$25 fee.

The MCO's will be allowed to present a short, fifteen-minute presentation, and then we do the breakout sessions like we did last time. So, the providers, if they want to ask specific questions,

we'll have breakout rooms. We'll have six breakout rooms. There will be the five MCO's and a Medicaid room.

2.0

And, so, if you want to talk about a specific thing like why is this prior auth weird on this issue, it seems to never link up or something, you can ask very specific questions. I don't think that would be during the General Session. I don't think that will be the case, but in those specific sessions, you can.

And we found those very helpful last year as providers; especially clinics and multi-specialty groups and big-provider practices, they had specific issues for one specific provider of getting credentialed or getting something and they were able to resolve a lot of that. They also got to know their local managed care network representative, which getting a hold of a local person if you've got an issue, that always seems to be a quicker resolution.

And, then, DCBS is having a workshop. DCBS has like 6,000 employees. And, so, they're going to use this time to actually have a workshop for their people to discuss a variety of things that they've got going on. So, they're just tagging onto the meeting and having a workshop there.

And, then, the second day, 9:00 to noon, there are four sessions and it's the Department of Insurance, Behavioral Health, Public Health and BHDID, the Department for Community Behavioral Services, or, I'm sorry, DCBS. So, Behavioral Health, DCBS, Insurance and Public Health. Those are open to the public and if providers or office staff have questions and want to talk about specific things.

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Public Health, they operate as sort of independent local health departments. There's certain things they're required to do as being part of that, but, then, their programs and services they render, they're basically their local board's choice as to what they're going to do. There's certain things they have to do but they can provide a variety of services. So, that will be the basic audience for Public Health.

Behavioral Health, I think we're going to get a lot of the new providers, the expanded network, the new services, lots and lots of discussions there.

And, then, the Department of Insurance, whether or not people have issues with that, that's part of that breakout session.

And, then, the DCBS, many people

refer to the DCBS office as the Medicaid office because, in the past, that's where you had to go to sign up for Medicaid, and that world is changing dramatically because of the success of our Kynect and online and things like that, but also that will be pretty much for the other--because there's such a big population of DCBS workers, so, that's an invite only, too, which I think is really aimed at the local DCBS offices and their employees. And they're just breaking them up so they don't shut the office down.

2.0

So, that's the agenda. I want to make sure you guys, if you can, pass this along in any format to remind people, send them notes, your associations, just make sure the word gets out that that's happening.

MS. BRANHAM: Commissioner, I have a question. On the Department of Community-Based
Services that are going to be having their meetings,
working with them directly for Waiver services,
providing Waiver services now that we've gone to the
1-800 number to try to request and see where prior auths
are and things like that that have been circumstance for
home- and community-based providers in the state, I
wonder if I would like to direct something to them about
how to assist us in getting some of these prior

authorizations that are bottlenecked up and this particular department freed up, how would I direct that, then, since this is an invite only?

COMMISSIONER KISSNER: Teresa James, my counterpart.

2.0

MS. BRANHAM: Thank you.

COMMISSIONER KISSNER: We've

completed an open enrollment for Medicaid members. That was the old Medicaid members prior to 1/1 because the people who joined in the ACA, they haven't even been in the program but six months so far or going on seven.

We sort of got out of sync. I think we mentioned this to you guys before where the first start date was 11/1, and, so, we kept doing open enrollment kind of in the summer to get everything done for an 11/1.

And, then, we made the change in Region 3 to go managed care on 1/1/13. So, then, we started getting into a cycle where we had an 11/1 effective date for seven regions and an open enrollment period prior to that, and, then, we had a 1/1 effective date for one region with an open enrollment prior to that and they didn't line up.

And the feds say you have to have a minimum of one open enrollment period per year. You

have to give them an open enrollment opportunity.

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So, we asked if we could push it, push the seven regions to line up with a 1/1 and they said no and we said okay. So, we did this one. So, what we're going to do is the opposite. We're going to have a shorter. So, we're going to do an open enrollment period for everybody, the whole state, at the end of the year.

So, we just did one for seven regions, but we're going to do another one for everybody which will include Region 3 and all the other regions for a 1/1 effective date and we'll do that at year end, and we'll give them the opportunity to make a change, and then we'll all be in alignment. That's the goal is that we only do one open enrollment period a year and it will all be with a 1/1 effective date.

So, that's coming and we sent out some materials on that. I don't think there was a significant - Neville - wasn't significant open enrollment changes.

 $$\operatorname{MR.}$$ WISE: Eight thousand or something.

COMMISSIONER KISSNER: Out of 600,000, something like that, so, not a lot of change, which is good. That's what we want.

1 I've included - as you guys have 2 come to realize, I am very big on transparency. So, I included the HP report which is how we pay for 3 fee-for-service in here and that's in Section 11. 4 5 That's the Operational Report for HP and it's what they do in terms of processing still paid claims in the old 6 7 fee-for-service world which is primarily nursing homes and the Waiver Programs. So, it's their metrics there. 8 9 And, then, they also do a slight adjudication. They don't really adjudicate at all. 10 11 They're the people who accept the encounter data from 12 the MCO's and they run it through a few edits to make sure it fits into our system and then we load the claims 13

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but it's lots of data.

The Medical Director meetings, Dr. Langefeld has his reports in there, the published documents so you can see what he's talking about there.

data there. So, that's all part of that Operational

Kentucky MMIS Report. So, that's good bedtime reading

We went through the quality recommendations, I think, the PIP, but Dr. Langefeld did not go through the quality improvement recommendations. Did you do that?

DR. LANGEFELD: Yes.

COMMISSIONER KISSNER: We did both

those. Okay. So, we're solid.

2.0

And, then, our responses back to the MAC on a variety of things.

We have also started, in Section 12, we started a community calendar. The MCO's, they're out and about all the time with tables, booths, fairs, going to vendors, going to provider offices and setting up whatever. So, we said we should have a better tracking of that for a variety of reasons.

So, we asked them to give us their information of where they're going to be and what the event is, and we do periodic audits of that. It's a fine line on marketing. You could set up a booth and answer questions but you can't go out into the audience and say, hey, come over. They can come to you. You can't go to them is basically the line.

Anyway, we do that. We do periodic audits and have that calendar online. We try to color code it. I'm not really sure if that comes out in the backup but every MCO has its own color.

So, that's where we are. I think I'll just open it up for questions. I made a presentation, which we did not get in here but I'll have it the next time, the presentations that we made to Health & Welfare which that's public. It's already out

there if you guys were interested, but I'll make sure you get a copy of it, the presentation of Health & Welfare.

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And also today after this meeting, I'm presenting at Appropriations & Revenue. I'm presenting to them as well. So, you'll get copies of those presentations.

And when we do the forum, after we do the forum presentations, you'll get a copy of that Medicaid presentation as well. We can try to get you copies of all of the presentations just so we have it on our website.

In the Health & Welfare, that was down in Owensboro last week. They took the show on the road and went down there - a beautiful facility. The Owensboro hospital is really a state-of-the-art, fascinating facility, an auditorium that is better than every movie theater I've been in in Kentucky with a huge screen. It was just a wonderful facility and I'm glad that they're using it for a variety of different things.

DR. NEEL: Now if we can just pay for it.

COMMISSIONER KISSNER: That's a separate issue, but a beautiful facility. And, so, we had that meeting down there.

I gave them an ACA update; and in that update, I'm doing this from memory, but we have filed like twenty-six or twenty-eight State Plan Amendments and most of them had to be done prior to the 1/1 effective date. We have six that are still open and pending in various states of discussion with CMS.

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And, then, those State Plan benefits link to our regs, and everything we do is in reg. So, that generated about forty-eight regulations that we have put through, and forty-four of them were emergency and ordinary regs which, it's my understanding, it's not necessarily the preferred way to do it; but when you have a start date of 1/1 and emergency regs become effective the date the Governor signs them, and, then, you file an ordinary reg where you follow up and it goes through the comment period and the normal cycle of review and everything.

So, our preferred approach I think from just a general practice would be to do ordinary regs and just let them go through the process. It takes somewhere between three and six months on average, closer to six, to go through that process. You do public notice. You do a variety of things and that's the way to do it.

We had a change of benefits, we

had a start date of 1/1, and the only way to really make that happen was to do emergency regs and follow it up. We did three ordinary regs.

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We did one emergency reg that we didn't follow up with an ordinary reg and that was to do I think some SCL changes. As we transition on the SCL, we wanted to extend the old payment structure for six more months to create a little bit more transition time for the providers and the members. So, we did that and then we let it expire.

So, we updated. There's a couple of maps in the presentation that are really great maps to have. One of them is the percentage of uninsured people by county prior to the ACA and it's color-coded similar to Dr. Langefeld's presentation. So, it's all red and then it turns all blue because we have a lot fewer uninsureds.

The biggest question for us was from a budget perspective because 100% federal funds is 100% federal funds. The State funds, 70/30, is the old Medicaid. So, they asked a lot about the woodwork, sometimes referred to as the welcome mat, but what about the people who are there today who are not in the program today? Under the old standards, they were eligible but they just never signed up.

So, the fact that you start to communicate more and make it easier and simpler and get more information out to the marketplace, people come out of the woodwork or step onto the welcome mat and they're eligible for care, and that's a 70/30 - 70% federal funds, 30% state funds. So, that's the significant hit to the state budget and that was our concern.

2.0

So, we had estimated 17,000 woodwork members in the White Paper that we've given to you guys in the past. It's also available on the Governor's website.

And what it looks like was that the adds and deletes have kind of been consistent, and we're going to come in at or below our expectation which is really good. The woodwork hasn't--you know, even though we estimated 165,000, 170,000 people sign up and we signed up close to 300,000, it's all new members. It's all above the old threshold members.

So, a lot of that is entirely federal funds, 100% federal funds for three years and then it starts to decrease over time as according to the ACA. So, that's really good news from our budget because, from a budget perspective, we have a very challenging budget.

From what the Governor requested

to what was actually approved is \$32 million of State funds less than what we requested, or at least than the Governor requested. So, we have to figure out a way to do that and that's always a challenge but it's a challenge we'll take on.

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So, I open it up for questions.

CHAIR PARTIN: At the last meeting, you said that you were meeting with the Governor just after the MAC meeting and that you were going to come back and report to us about that meeting.

COMMISSIONER KISSNER: So, we met to discuss the budget. And right now, I think we're going to do a wait and see. One of the places that the Legislature said, you know, we're giving you increased slots in the Waiver Program, and those Waiver slots, you can phase them in as a way to help meet your budget.

So, we're reviewing that right now and coming up with some final recommendations on what we're going to do. By pushing those slots off a little bit, we'll get them all in this state fiscal year, but we'll get them down the road instead of effective 7/1.

But other than that, we're really on a sort of wait and see in terms of the budget and what happens and where we stand and let's get a few months down the road in terms of 7/1, 8/1, 9/1 and see

where we stand before we make any radical decision.

2.0

DR. NEEL: The consideration of what will happen whether the ACA enhanced payment for primary care continues, it's in the President's budget, I understand, but whether that will be continued for another year or two, do you all have any feeling for that yet or do you have a Plan B should that not be as far as reimbursement for primary care?

COMMISSIONER KISSNER: We do hope that the federal government continues to do it. I just completed a MACPAC survey which is Medicaid Advisory Committee or something for DC. It's like MAC but at a national level.

MS. LEE: Payment and Access Commission.

go. Medicaid and CHIP Payment and Access Commission about this entire issue. And we were unique in that we had created over the last ten years, seven years the PPC's and the primary care and how we were paying them at a PPS rate. We were doing a wrap payment on the PCC's.

So, we actually had, because of that, which was way beyond the enhanced payments, between 2006 and 2011, we saw a 35% increase in primary

Care providers in the State of Kentucky accepting

Medicaid. We saw a huge increase in nurses, nurse

practitioners, physicians. We saw a variety of provider

groups - family practice. We saw an increase as the

PCC's were formed and they hired more people and said

let's provide more service because there's a significant

reimbursement. So, we saw a significant growth.

2.0

Then when we went with managed care, the feds came back and deferred money from us.

They withheld I think it was \$9 million or something like that. So, we had to make a change pretty quickly.

And, so, on 3/1, we changed and said we're going to stop doing the wrap payment for primary care's. And where we ended up with them is we paid them 100% of Medicare. We went from a higher payment down to 100% of Medicare for primary care centers.

So, that's a significant population of providers that are getting 100%. So, they don't really benefit at all from the enhanced payment. It's just the stand-alone providers that aren't designated through licensure as a primary care center are the ones that are getting something less than 100% of Medicare that were getting enhanced up to 100% of Medicare, if you followed that. So, we hope they

continue.

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What the feds have told us, though, is what you're doing today can't continue if it doesn't get funded. We can't--because we're sort of playing the middle man where the MCO's say here's the services and the providers. We give them a list every month of the providers who have self-attested, right, because we have some that have come on over time, but here's the providers that are self-attested that say they're eligible for the payment.

They pay their normal claims and then they send us the claims data. We bounce it up against our information. We verify the codes and the providers and also what is the 100% payment number and we write them a check and say, okay, here's \$100,000. Go distribute it to these 100 providers. And the MCO's then take that lump-sum check and distribute it up and pay the providers. So, that's the way it works today.

The feds have said you can't do that after 1/1/15. You can't keep doing that. I mean, we could do the run-out of the 2014 payments because it happens forty-five days after the quarter, but you can't keep doing that because, in managed care, it's at-risk managed care payments. So, you either have to increase the cap payment to the MCO's or do it some other way,

but you can't keep doing the way you're doing.

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So, we hope if they extend it, that would be a great answer. A hundred percent of federal funds would be good, but I have not heard that that's going to continue, and I'm not sure the President's budget is going to--you know, we have to see where that ends up.

You should have on your radar screen that the CHIP funding, the federal CHIP funding ends on September 30th of 2015. It is my understanding - I'm not a legal expert in this regard and not a legal expert on anything - but it's my understanding the President can do a lot with executive powers, but what you can't do is procure money. You actually need a budget. That's how the world shut down the government for a period of time because you can't Executive Order your way on a budget. So, that's a budget item.

So, it's on everybody's radar screen. Something needs to happen with the House and the Senate at a federal level to continue the funding of CHIP. In theory, the ACA, when it was first passed, they said everybody is going to do it.

So, there really isn't any need because if a kid between 100 and 150 or 150 and 200 or whatever the CHIP levels were, they will be eligible to

buy a qualified health plan. So, they actually had that money expiring and saying you won't need it anymore.

2.0

Well, then, you have the states, twenty-five or so states that didn't expand, so, half the world didn't do it. And then what happens when that funding runs out? This is alarming but it's out there and we know there's an expiration date. And, so, something has to happen.

So, just keep your ear to the ground on that. If you see anything, let me know from any of your national associations because I'm sure everybody is concerned about the CHIP funding. It's something that the states couldn't continue to do it as 100% state funds. We have a tight budget as it is. So, I just throw that out there. It's important and it's pending.

DR. NEEL: The Legislature seems to collectively believe that they've solved some of the access problems now with the nurse practitioner bill, for example, feeling that they can supply nurse practitioners to rural areas to supplement physicians there.

And I can assure you that it's unsustainable for them to start practice or continue practice in those areas at 100% of Medicare, so,

something is going to have to be done.

2.0

I'm not advocating any particular thing versus nurse practitioners of physicians, but everybody is being underpaid as far as that's concerned, all the providers at this table, I'm sure. And I know that they don't want to vote more tax money or whatever to it, but we're going to have to face that if the ACA doesn't continue. Would you agree?

CHAIR PARTIN: Yes, absolutely.

COMMISSIONER KISSNER: And at the Health & Welfare down in Owensboro, the meeting was basically devoted to primary care.

So, everybody who was a primary care link presented, and the message was loud and clear and very consistent over and over that if you just take today's need, and we need another fifty to a hundred and fifty primary care providers a year between now and 2025 - aging population, a variety of things. We have a need today, and we don't manufacture fifty primary cares a year in the State of Kentucky. They're not homegrown.

And, so, what are we doing and really asking the Legislature to say, you guys, we need your help. They talked about tort reform which might be the third rail - I don't know - but tort reform and they talked about incentives to pay down loans and a

variety of things.

2.0

We have those programs in the state. We've done them for years, but do we need to expand them? Who pays for them? How do we entice existing primary care providers to come in to our state and open up shop? How do we grow more? They said there was residency issues with not enough residency for the ones who are graduating to even find a place to do their residency. We don't have enough of those.

So, some fundamental, just pipeline problems that I think need to be addressed at a global and higher level which to me makes sense. And they were very consistent. I'll say that. They were very consistent saying and framing the problem - we want primary care. We want more primary care. Here's what we need and we don't have enough. We don't have enough today and we definitely don't have enough as we're building them to meet the needs of an aging population and an expanded Medicaid.

We also put out a report because Auditor Edelen is doing a series of rural hospital focus groups, a listening tour. I'm not sure what he called it, something like that, but focus groups with local hospitals, and we provided a report based on the first six months of claims.

We did county by county, hospital by hospital, rural and urban, three years of data and said here's exactly what we've paid and all Medicaid dollars to this hospital, to each individual hospital.

This is by name. So, you've got a hundred hospitals - you've got these big giant reports - a hundred hospitals. You've got multiple years.

2.0

And the takeaway here is, one of the takeaways - there's lots of stuff in there. For people who are data geeks, it's wonderful, rich data. But in there, we took and said here's last year's DSH payment, which is the disproportionate-share hospital payment, hospital share, for their uninsured population.

Here's the entire payment for last year, and 45% of the hospitals, 45 of the hospitals down the list have already received in additional ACA payments for the covered lives more money for those services than what was paid last year's DSH, and DSH gets to continue unchanged for 2014 because the feds shifted it a year down the road before it starts to decrease because that was one of the funding mechanisms.

We said if we get everybody covered, we don't need to keep covering the uninsured through a disproportionate-share payment, so, let's start sort of ratcheting that down. So, that is the

plan. That is the ACA plan, but they've pushed it. The ratcheting doesn't start until next year.

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And that was only really, if you say it's six months of data, it was forty-five. If you doubled it to say it's twelve months of data versus twelve months of data, it was 78% of the hospitals will receive more; and if you assume--well, it's really not even six months of data because we just published it like last week and it included claims through June, and June claims are obviously not mature, right? There's a normal lag of claims' payment.

So, if you say it's three or four months, you get over 90% of the hospitals who are actually going to receive more money this year than they received for their entire DSH.

So, I think that's a positive sign that we're getting more people covered and we're sending more money that way. We wanted that out there as well to provide information, and I think that's available online as well.

CHAIR PARTIN: Are there any questions?

MS. BRANHAM: I have a couple. I know that at our last meeting, we talked about that Dr. Langefeld was going to present us with a recommendation

for a topic. What is the second one that's been chosen?

I'm sorry. I don't recall.

2.0

 $\label{eq:commissioner} \mbox{COMMISSIONER KISSNER:} \quad \mbox{The second}$ one is we let the MCO's pick theirs.

MS. BRANHAM: Okay. So, everybody possibly will have a different one.

COMMISSIONER KISSNER: Yes. Today we let them have two. For the next cycle, we're letting them have one. And maybe the cycle after that, we'll mandate both of them.

MS. BRANHAM: Okay. And, then, I was just reviewing the meeting notes from the Medical Director meetings. And, of course, you know, anything that comes to Home Health, I like to just be clear.

Under Section 12, for the Medical Directors' meeting, on the second page at the bottom of the page - they're double-sided - talks about Home Health Planning Update, and Andrea Adams provided an update regarding the Health Home planning activities since she has received all but one of the service inventory.

The group was also updated on the status of planning and initial data analysis. The initial views of the data will be discussed at the June meeting.

I flip to the June meeting; and when I look under the Home Health section there under Planning Update, I see that she provided an update regarding the Home Health planning activities. The group is starting to evaluate data as it becomes available. There's a planned meeting for June 23rd that includes presentation and discussion with Community Care of North Carolina and an active program focused on pharmacy utilization.

2.0

I guess I'd just like to have a little more information about what occurs in Home Health planning, and I guess is CCNC going to be giving you all Home Health planning information as well as pharmacy utilization? I just am not clear on that.

DR. LANGEFELD: Let me clarify the term first. So, this is not Home Health. This is Health Home, and Health Home is actually a designation under ACA Provision 2703 that that designates an opportunity for states to identify a process for a focus on treatment of chronic disease, specifically two or more chronic diseases or one with the possibility of developing another one, or severe and persistent mental illness.

 $$\operatorname{And}$$ with that, you can, then, receive funding at a 90/10 level actually for the care

coordination services around that activity and focus.

2.0

So, what we've done is there was an opportunity to apply for a planning phase grant of Health Home which we've done, and, so, Andrea is the leader of that Health Home planning initiative, during which we'll assess what's going on in other states, what's the opportunity, what does our data tell us about our population, where are opportunities and needs.

And then during that period, we'll make a decision about submitting an application for a formal Health Home provision which will include a State Plan Amendment or maybe more than one if that's the way we move.

MS. BRANHAM: Okay. I got you now. I misread that, but I do know that a couple of the MCO's have started already talking about the CCNC. And I don't know that folks are even clear what their exact model is here in Kentucky, I guess, since it involves that medical home, not just for pharmacy, but for other utilization of services and I guess the more medically fragile population.

DR. LANGEFELD: It actually is a program in North Carolina, and their system is organized much different than ours, but their program and their programmatic activity and the structure of how they are

approaching things has some valuable things for us to learn from.

2.0

So, we've had a presentation. I think there's some active discussions occurring and initiatives around the state. And, so, the dialogue will continue, but it's really more of an exploration around what's happening in other states, what's a model that we could look at to learn from and not reinvent the wheel. So, we'll continue that process.

MS. BRANHAM: Thanks.

CHAIR PARTIN: Anything else?

Then, let's go ahead and move on to the reports from the various TAC's.

Behavioral Health.

MS. MUDD: I'm obviously not Sheila Schuster. Good morning. I am Valerie Mudd, serving today as the spokesperson for the Technical Advisory Committee on Behavioral Health.

Our TAC had its most recent meeting at the Capitol Annex on July 10th. We invited all five of the Medicaid MCO's and their Behavioral Health representatives to attend. All MCO's were represented and all but one - Anthem - had their Pharmacy Director with them.

In addition to the MCO

representatives and the five TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the Kentucky Mental Health Coalition. We also had staff from the Kentucky Department for Medicaid Services and Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities in attendance.

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A summary of the Behavioral Health TAC report made to the MAC in May of 2014 was disseminated before the meeting and was briefly discussed.

A number of new items were on the agenda initiated by the TAC members and others in the behavioral health community. Input on each was received from the MCO's as well as from staff of DBHDID and DMS.

1. Availability of Assertive

Community Treatment if the individual is residing in a

Personal Care Home. The MCO's stated that medical

necessity was the criteria, not where the member lived.

2. Question whether an individual who gets ACT services, we were wondering, can they get therapeutic rehabilitation services. The closing of so many TRP's is a significant problem. The Department for Behavioral Health, Developmental & Intellectual Disabilities will hare service standards. All agreed

that the full continuum of care is not available.

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3. Are targeted case management (TCM) and community support services mutually exclusive? Humana/CareSource indicated that they had changed their procedure here and were approving TCM and community support services.

4. And we were wondering. Can someone who does not have an serious mental illness diagnosis get peer support services? Peer support services are not restricted to individuals with a severe mental illness diagnosis is what we found out.

5. Some individuals who are dual eligible (Medicare and Medicaid) are being denied crisis stabilization services and the CMHC is being told to refer the person to the hospital. What happens if the hospital does not admit the individual? Is this a case of the MCO shifting costs to Medicare and sending members to a higher level of care?

Lengthy discussion of these issues with the general consensus being that members who need CSU or crisis stabilization services are not likely to meet hospital admission standards and need to be sent at the CSU. That's a real problem.

6. What is the current status of Impact Plus from the MCO perspective? What is happening

with newly-identified youth who need intensive services? The changes in the Impact Plus Program were again discussed and the MCO's reported that they are credentialing a number of providers of Impact Plus services who will now be providing these services under managed care. Everyone is anxious to see the Behavioral Health Services Organization regulation and begin the process of being licensed in this new category.

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While there has been progress made, there are still concerns about the service array for children with intense needs and how accessible those services will be. It was noted that Impact Plus will be discussed at the July Health & Welfare Committee meeting and it is hoped that more information and clarification will be available then.

The ongoing problems with access to appropriate medications were discussed, particularly with regard to Abilify. We were able to discuss those issues with the WellCare Pharmacy Director who was present.

They do have a fail-first policy, which consumers, family members and advocates at the meeting did not think was in the consumer's best interests.

Other pharmacy reps reported on

their procedures, all of which require prior authorization. With regard to injectables, all require a first trial on the oral medication to assure that there are no side effects before the injectable, a 30-day injection, would be approved. Pharmacies do have the ability to give a three-day supply in an emergency, and all pharmacy directors encouraged direct calls to them when problems of access arose. So, we found that very positive.

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There was again discussion about the administrative burden experienced by those providers (CMHCs, private child care facilities, hospitals) who have contracts with all five MCOs, each with its own forms, procedures, criteria, and we talked about that today.

The lack of consistency of forms and procedures creates a huge administrative and resource burden for providers. The TAC will invite MCO's to share their ideas about streamlining procedures and creating consistent forms and will ask for the opportunity to present this information to the MCO Medical Directors convened by Dr. John Langefeld.

We continue to ask the MCO's to provide information to us about openings and opportunities for consumers, family members, advocates

and providers to serve on their committees. These requests would then be circulated through the KMHC and other forums to recruit interested persons.

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Recommendations: That Kentucky

DMS carefully monitor the hospitalization/
institutionalization/out-of-state placements of Medicaid

members and reevaluate the reimbursement rates for
services such as intensive case management and
outpatient therapies in light of this data.

Specific data on readmission rates for individuals needs to be tracked and analyzed to get a full picture of what is happening to members with behavioral health needs.

Finally, the Behavioral Health TAC wishes to state again this recommendation made more than one year ago: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system.

This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCO's in order for them to access the care that they need.

Thank you for providing this forum

to bring forward behavioral health concerns on behalf of the Medicaid members.

CHAIR PARTIN: Have you gotten a copy of that report to Barbara?

MS. MUDD: Yes.

CHAIR PARTIN: Next up is

Children's Health. Consumer Rights and Client Needs.

Dental. Nursing Home Care. Home Health Care.

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MS. BRANHAM: Hi. I'm Sharon Branham. I'm Board Chair of the Kentucky Home Care Association and Chair of the TAC.

We had our meeting on Tuesday here in Frankfort, and we've been away at a strategic planning conference. So, we haven't had time to submit our TAC minutes to you, but I told Barbara we would have them to her tomorrow and then they can be made part of our meeting minutes here.

our TAC meeting which we had resolution with, I'm happy to report, would be prior authorizations for services for EPSDT. So, we've got good movement and good support from the MCO's regarding that and a bit of time rather than thirty days or what-have-you on implementing services for these kids. So, that's been moved anywhere from three months to six months with submission of notes

and things such as that.

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I guess program codes were released and those are being placed on the website according to Erin.

Private duty services were discussed. Lee, Pam was talking that you and Charles are probably going to be trying to get some of that information on the Cabinet website as well because there's still some missing components that relate to maybe it's the map and the supply codes and private duty code and then the difference with HCPCS codes or procedural codes versus revenue codes. So, I guess those are being tended to by yourself and Charles.

Those services have been implemented in our state, but I guess it's all having to be handled a little bit differently because of how the implementation came forward with ACA, and that's being worked through, I'm happy to report.

One thing that I did mention to the Commissioner and that's this ability for home health agencies to work with local DCBS offices on approval of Waiver services to be implemented, and it goes to this 1-800 number and how that's causing a backlog on ability to obtain services in a timely manner for recipients that need these particular Waiver services.

So, I will be addressing that with Commissioner James because we can't get any followup now because it's going to a 1-800 number. We did have a couple of suggestions about faxing requests so we would have that document. So, we appreciate the suggestions that came from the Medicaid staff regarding that.

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Provider enrollment. We've seen a little bit of slow movement in the opening up of that and new patients coming forward and then the MCO's expanding in specific areas.

I guess we've had a new, not necessarily regulation changes but updates to the home health services' regulation, some cleaning up of that, and I guess those were approved and those are I guess going to be put on the website very soon this week as well.

The MCO's came to our spring conference and met one-on-one with providers that were there and we appreciate them going forward. And I'm happy to report that really, across the state, I think that home health providers have been able to work through a lot of issues that we were having with the MCO's.

We have a couple of outstanding issues from agencies, particularly health department-

based home health agencies that I've brought to Coventry's attention but haven't been addressed yet. So, I encouraged the representative at the TAC meeting to please respond to my email as well as the particular entity that's having problems. And I noticed in the binder that it looks like they haven't responded to you all as well. So, we must be having the same kind of issue.

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I'd like for you to know that as service providers of Waiver services in the state, that our association and committee that's been appointed are working very diligently with Commissioner Anderson on we're calling the Super Waiver to assist in that being a win/win for everybody in the state - for recipients, for the State to assist in their expenditure for the Medicaid budget and long-term care dollars.

Really, I think that's about all I have to add today. And if anybody has any questions, please feel free to ask.

CHAIR PARTIN: Thank you.

Hospital TAC. Pharmacy & Therapeutics. Nursing Services, and there was no meeting. Optometric Care.

DR. WATKINS: We've not had a TAC meeting. And the only thing that's been brought to my attention as a concern, we had an issue with WellCare,

their latest information that we came out with.

I understood in July that as of July 1, there are no copays with WellCare. That is true? I do want that clarified one more time.

CHAIR PARTIN: WellCare.

DR. WATKINS: That is true?

WELLCARE REPRESENTATIVE: That is

true with the Exception of Region 3.

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DR. WATKINS: Okay, because I'm still seeing people present cards and patients that are unaware or really not sure whether they have a copay or not, and I'm just making sure that we are telling them correctly that, yes, they do not have a copay.

And on the back of their card, there is just a number to call for vision services. And in the packet that they received, it told about frames and lenses that were available and it did not clarify to them that that was only available for patients up through the age of twenty-one.

And it's our understanding that that is still the same as it is with traditional Medicaid, that that is true, that that stops at the age of twenty-one across the board with every type of MCO as with traditional Medicaid, that vision services as far as an exam are covered for all ages, but frames and

lenses do stop at age twenty-one, and that's something we've had difficulty with our patients because they think this is a new benefit that they are receiving with WellCare, and we're having to burst their bubble. So, I would want to make sure that that is clarified with the patients unless they have expanded their benefits and the providers are not being notified of this. Can I get a clarification on that?

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MS. RANDALL: I'm Rebecca Randall with WellCare, Manager of Regulatory Affairs. We were very familiar with the confusion.

The confusions stemmed from a mailing that went out to our member population which communicated the new benefits effective 7/1/2014.

Within that grid, there was a vision benefit with zero copay. However, the age restriction was not clarified in that communication. It did state that restrictions apply; however, it was not specific that it did not list under the age of twenty-one.

But to answer your question, that benefit, our vision benefit has not changed. That age restriction is still in place. And moving forward, we have corrected our member communication. We've corrected our website. Any further materials that go out to our member population, we'll make sure to include

that age restriction on there.

DR. WATKINS: Thank you. That's

all.

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CHAIR PARTIN: Thank you. Therapy

5 Services.

MS. ENNIS: Good morning. I'm

Beth Ennis. I'm the Chair of the Therapy TAC. We have

met monthly for the last few months just to try and

resolve some things within the TAC that we don't need to

be pushing on the MAC, and the Cabinet has been very

good about responding to questions that we've submitted

to the MAC. So, we appreciate that tremendously.

The responses that we got from the last MAC meeting were that there is no thirty-day re-cert for fee-for-service Medicaid therapy services. It's a twenty-visit benefit. So, we're still working through the process of why when people get their prior auth they're being asked to re-cert in thirty days. So, we've got a method to work through that and we're continuing to do that.

The hospital-based OT restriction has been resolved in reg. I think the last word I got was July 7th, somewhere in there, the reg got approved. So, outpatient services through OT in hospital-based outpatient clinics is now allowable.

The only question that is still kind of on the radar - and I did email it because our minutes from this morning were not finalized yet - is the differential between therapist and assistant and how that's going to be consistently applied across providers because some providers bill under a facility NPI versus a provider NPI and there's no way of knowing because it's billed by code and there's no difference in the rate code.

So, people don't want to be billing fraudulently inadvertently and how is that going to get addressed through the billing process? There is only one MCO to my knowledge that is also applying that differential. The others are not. So, it's predominantly a fee-for-service issue but we did submit that question through email this morning.

That's all we've got.

CHAIR PARTIN: Thank you.

Physician Services.

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DR. NEEL: Yes. Physicians TAC met this morning and we had a very good meeting. We talked about a number of items.

One is the problem with taxonomy numbers and where they're placed on the HCFA 1500 form. There's been some problems with people getting paid

because the number is in the wrong place, not that it's a wrong number. So, we're trying to work that out at the present time.

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A number of providers continue to complain that the credentialing process is taking too long. And it appears that we've got to start by getting credentialed with the MCO's and then go to Medicaid for credentialing and that a reasonably short period of time.

So, we would encourage the MCO's to work as hard as they can to get people credentialed as quickly as possible because we're hearing that, although they're paying retroactively once they're credentialed, that sometimes that's creating quite a cash flow problem for a lot of providers.

As far as coding and payment for physical exams, I've talked to Dr. Langefeld about that. We hope that there will be a dialogue continuing. We understand that Medicaid will only pay for one well visit per year, but we're trying to work around what we're going to do with school physicals and sports physicals and I hope that dialogue will continue because that's continuing to be a problem.

The biggest problem at the moment is that the providers are coding under different numbers

for the same exams and we're concerned about what we're really doing with those. So, I hope that will continue.

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Misassignment of patients continues. That's been particularly a problem with WellCare since the beginning more so than the other MCO's. That has improved somewhat but continues to be a problem. Fortunately, most of the people don't look at the physician name on the card. You're my doctor, and, so, I never noticed that some other doctor was on my card. I guess that's good in a way but it makes for

problems and we hope that will improve.

The other thing, and I directed this to Mr. Kissner, is that do we have to have two medical cards for every patient? I have mothers with four kids. That means she has eight cards. If she changes anything at all, then, she has sixteen cards and another month she has thirty-two cards. And a lot of them don't understand that the Unbridled Spirit doesn't mean Kentucky Spirit that it did before.

So, is there a chance we can do away with that one card and just have an MCO card?

COMMISSIONER KISSNER: I don't

know. When you guys get a quorum and if you make a recommendation that you want to eliminate that, vote on that to eliminate the card. I don't know that that's

2 that. 3 So, if, in fact, you guys vote, say, our recommendation is eliminate the Unbridled 4 5 Spirit card completely, we can definitely research that. I'm not sure what they use it for other than they're 6 7 getting the card and we just haven't turned it off, and I don't know if that's linking to anything else like 8 9 SNAP. MS. LEE: HANDS, First Steps. 10 Some services are not included----11 12 COMMISSIONER KISSNER: HANDS, First Steps are in that. That's what that card gets you 13 14 is the other services that we pay for outside of the 15 managed care. 16 DR. NEEL: All right. So, first 17 we work on a quorum, right? 18 COMMISSIONER KISSNER: A quorum 19 and then we'll make sure the other groups are agreeing 2.0 that they want to do that. 21 DR. NEEL: Thank you. That's my 22 report. 23 Podiatry Care. CHAIR PARTIN: 24 Primary Care. Intellectual and Developmental

uniformly across all provider types, haven't addressed

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Disabilities.

We can't approve any

recommendations because we don't have a quorum. So, I would just ask that all the TAC's hold their reports—well, actually submit them to Barbara and then, Barbara, will you hold them until we do have a quorum and then we'll submit them all to the MAC for approval of the recommendations.

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MS. EPPERSON: That's fine.

CHAIR PARTIN: Any New Business?

DR. NEEL: I want to bring up one item, and I'll bring it up here quickly because it was mentioned in the Medical Directors' report, and that is the status of immunizations.

We've worked for years and years to get our immunization registry up and running and it's been doing, we think, a great job. It's now been taken down over the last month. It couldn't have happened at a worse time for those of us that are out there trying to make sure the immunization level is up and gets kids ready for school.

I noticed in the Medical Directors' report the deterioration of our immunization levels and that's so important. So, you might want to bring that up. We've got to get that registry active again.

DR. LANGEFELD: Absolutely. This is a national issue with immunizations, period, and we've seen a resurgence of several things and an increase and, so, how to address getting that number back up and the trend in the right direction.

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The immunization registry I don't have any specifics around. What I've heard indirectly with discussions is that it has more to do with a technical issue around the vendor that was supporting that.

DR. NEEL: I'm aware of that.

DR. LANGEFELD: And I think that's an ongoing active discussion and certainly an area of concern but I don't have any more information about that, but the discussion about immunizations will continue to be an active discussion.

DR. NEEL: Okay, because where it involves Medicaid is we have a lot of family practice doctors and now pediatricians, too, who are not giving VFC vaccines and sending children to the health department which is overloading health departments in a way, and then the exchange of information becomes a problem. So, it does affect Medicaid recipients in that we've got to keep their levels high.

DR. LANGEFELD: Yes, absolutely.

1 The VFC Program, Dr. Brawley (sic) came and had the 2 discussion at the Medical Directors' meeting about just 3 to begin the dialogue about what are the options because there are logistic issues, as you well know, with 4 5 storage of the vaccine and the quality control around 6 that, not just administration, and the cumbersome 7 hurdles that sometimes exist in that program itself. So, we'll continue that dialogue. 9 DR. NEEL: Thank you. 10 CHAIR PARTIN: Anything else? 11 This has been a short meeting today. 12 COMMISSIONER KISSNER: I have one more last news to introduce Leslie Hoffman sitting 13

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behind me. She is taking over Karen Martin. anybody who deals with the Waiver side of the house, they were all under Karen. Now they're under Leslie.

She comes back to us from working in the community mental health center arena and prior to that work was the Assistant Director in that unit. So, she comes back to Medicaid with familiarity and now a complementary experience with the mental health system. So, we welcome her.

CHAIR PARTIN: Thank you very much, everybody, and we'll see you next time.

MEETING ADJOURNED